Myths that Fuel Resistance to Public Health and Hospital Collaboration

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2016

Public Health Foundation

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May 2016

Introduction

There has been a lot of discussion about the need for more strategic coordination between public health and healthcare, especially hospitals. One reason is that there are increasingly limited dollars for public health, so we have to be efficient and effective as we try to improve health in our communities. Everyone wants to keep the cost of healthcare manageable while optimizing outcomes, and hospitals and health departments are working together more closely toward this end. The forms these partnerships take and the specific organizations that participate depend on each community's history and needs. The key to success is having committed, trusting partners, a clear mandate and organizational structure, and adequate funding. But where there is not a tradition of working as true partners, the path is rocky.

There is tremendous promise in effective hospital community benefit activities. The requirement for hospitals to do community assessments and implementation plans parallels health department accreditation requirements. All of these organizations are working to have effective systems and methods for collecting data, understanding data, communicating to the community, and then taking community-wide action to address health challenges systematically.

A 2014 report by the Commonwealth Center for Governance Studies[5] outlines the core characteristics of successful partnerships between health departments and hospitals, offering several recommendations for groups seeking to have effective collaborations:

- Hospitals and public health departments should be at the core, but a broad range of partners should be included.
- When possible, partnerships should be framed around existing, trusting relationships among at least some of the partners.
- A partnership should adopt a mission and goals that focus on clearly defined, high-priority needs that will inspire community engagement and support.
- One or more anchor members are needed to provide financial support.
- A designated body with a clearly defined charter should be created.

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[5] "Improving Community Health through Hospital-Public Health Collaboration," Commonwealth Center for Governance Studies Inc., November 2014. Accessed on April 5, 2016: http://www.uky.edu/publichealth/sites/www.uky.edu.publichealth/files/Research/hospital-public%20health%20partnership%20report_12-8-14.pdf

- Population health concepts, definitions and principles should be well-defined and mutually understood by those involved.
- Community health measures, objectives, targets, metrics, and tools should be selected.
- Develop and disseminate impact statements that measure the effects of the partnership efforts relative to the direct and indirect costs of the partnership.
- A deliberate strategy for broadening sources of financial support should be maintained.
- Boards of participating organizations should establish standing committees with oversight of their participation in the partnership.
- Federal, state, and local agencies; hospital associations; and public health associations should adopt policy stances that promote cooperation between hospitals and public health departments.

Despite these recommendations and a growing number of effective collaborations, this type of work just does not get off the ground in many communities. Thoughtful professionals from both groups maintain that they want to collaborate, but believe factors beyond their control prevent it. Below we examine myths that seem to fuel these beliefs, and offer alternative perspectives. In most instances, the myths are perpetuated from both sides (see Table 1). We hope these observations encourage public health departments and hospitals to reexamine their assumptions, and come to the table with renewed momentum and commitment to collaboration.

• *indicates the myth persists within organizations of this type*	**Health Departments**	**Hospitals & Health Systems**
#1: "Timetables Cannot Be Reconciled"	•	•
#2: "They Are Reluctant to Partner with Us"	•	•
#3: "Hospitals Have Deep Pockets"	•	
#4: "We Should Focus on What We Know and Can Control"	•	•
#5: "Collaboration on Implementation is Not Necessary"		•
#6: "Collaboration Is Too Expensive and Takes Too Much Time"	•	•
#7: "Failure is Unacceptable"	•	•

Table 1. Myths that Fuel Resistance to Collaboration

Myths that Fuel Resistance to Collaboration

#1: "Timetables Cannot Be Reconciled"

Certainly there are timing challenges for hospitals, health departments, and other entities collaborating on health assessments and improvement activities. Many health departments conduct community health assessments on a 5-year cycle, while non-profit hospitals and health

systems use the 3-year cycle required by the IRS. In addition, these organizations may not follow the same fiscal year calendars, which can complicate planning, communications, and coordination.

However, timing need not be an insurmountable problem. Health departments are often willing to conduct health assessments more frequently, especially if the effort and cost can be shared with others. In Maine, for example, part of the initial agreement among the state health department, the district liaisons for public health, and four partnering hospitals was that everyone would conduct assessments every three years. The key is making an upfront commitment to the shared timetable. It may take some initial effort to get calendars aligned, but it is well worth it. If irreconcilable timetables are cited as the primary barrier to collaboration, it may be a scapegoat masking a deeper, subtler challenge. In such cases it is worth considering whether other myths are playing a role.

#2: "They Are Reluctant to Partner with Us"

This assumption can become a self-fulfilling prophesy. In any new partnership, missteps or tentative gestures – both common in the initial part of collaboration – can easily be misinterpreted as unwillingness. This in turn reinforces doubts on both sides about moving forward.

In the case of collaborations between hospitals and public health agencies, the historical context contributes to apprehension. Many community agencies are not used to partnering with hospitals, and hospitals have not always have been willing partners. While non-profit hospitals are now required to do health assessments and implementation plans, and to report impact, all this is relatively new; in the past, many hospitals limited community benefit activities to providing reduced cost or free care to patients. In some instances, corporate hospital entities have done only the minimum required by law. Thus, potential partners in the community remain skeptical about whether hospitals will come to the table and stay there. In our experience, this mistrust will diminish with time and experience, but initially working together may require a leap of faith.

#3: "Hospitals Have Deep Pockets"

Hospitals may believe that public health departments are primarily seeking financial support rather than a substantive partnership. The stereotype that hospitals have "deep pockets" is often far from the truth, and feeds cynicism about the motivation of public health agencies. Some hospitals' attempts to collaborate on heath assessments are rebuffed by state or local health departments that are determined to work independently.

Hospital community benefit activities are often funded by hard-won dollars. When hospitals do not have extra money to put into population health initiatives, some use grants to fund community benefit work; hospitals and community organizations may compete for the same grants. Applying for the funds together is a solid approach that funders are encouraging. For

example, the BUILD Health Challenge (jointly funded by five philanthropies) requires a coalition approach led by health departments with a match of grant funds by the partnering hospital.[6] Such funding can ensure a well-facilitated process in which hospitals join a team of partners, all of whom do what they can – even if it is not as much as public health agencies would desire.

#4: "We Should Focus on What We Know and Can Control"

This sentiment is more of a caution than a reason not to collaborate. Each organization naturally brings unique priorities and expertise to the table, and wants to make the greatest impact given their strengths, resources, and mission. Thus, hospitals have focused on specific patient populations; whether high utilizers of care or high-frequency ICD-10 codes, the denominators in hospitals' population health measurements tend to reflect who walks through the hospital's door (population with a lower case "p"). Health departments, on the other hand, tend to study and try to impact populations across a geographic region (population with a capital "P"). While hospitals may shift to a broader population over time, they are still investing primarily in their patients, and look to public health to focus on everyone else.

All of this work needs to be done, rather than one or the other. The individual organizations do not have the expertise to accomplish alone what they can together. The solution is an intricate dance in which each carries the burden of doing what it knows how to do, which should be thoughtfully informed by that the other is doing. Because hospitals and public health departments have different areas of expertise and comfort, there is often a tug and pull that can lead to "scope creep." Thus, partners should identify the mission and reach of a joint project and stick to it.

#5: "Collaboration on Implementation is Not Necessary"

Community collaboration is absolutely necessary. While the IRS does not currently require hospitals to partner with health departments on implementation plans, the Public Health Accreditation Board does require such collaboration of health departments applying for accreditation. But whether required or not, whether pursuing accreditation or not, collaboration is not optional if health improvement efforts are going to succeed over the long term.

But what does that collaboration look like? The organizations need to know what each other is doing at a minimum, but this is only a start. Having a person from the hospital sit on a community planning committee is a good step, but that is not collaboration. Identifying shared strategic goals that reflect the meaning of the partnership can help ensure that pockets of shared work on discrete projects (which touch relatively few people or needs) are not used as evidence of widespread collaboration.

[6] The BUILD Health Challenge, accessed on April 7, 2016: http://buildhealthchallenge.org/

#6: "Collaboration Is Too Expensive and Takes Too Much Time"

Everyone can say collaboration is a good thing, but it still falls to the bottom of the list because people are stretched too thin. People hear "collaboration" and believe it will take extra time and money. Some believe that a collaborative health assessment that involves multiple community partners will require that either the hospital or the health department (or both) have a dedicated staff member. Hospital staff may be spread so thin that the challenge may be making the time to reach out effectively to partners in the community. However, in many cases, employees from both entities do this work as part of broader roles. Knowing the right person to communicate with in the other agency saves time and energy.

There is also a worry that collaborative data gathering and analysis will be more costly than separate efforts – perhaps anticipating additional meetings, clearance processes, and bureaucratic hurdles associated with the collaboration itself. However, this need not be the case. In 2010, three Maine hospitals collaborated on a community health needs assessment at a cost exceeding $400,000. The same year, the state health department conducted a statewide health assessment for $225,000 – for a combined cost of $625,000. When they all collaborated on the assessment in 2013 (adding a fourth hospital to the mix as well), the total cost was $330,000. Furthermore, the resulting report was more comprehensive and useful than the separate reports had been three years earlier.

#7: "Failure is Unacceptable"

Having seldom collaborated with one another in the past, the stakes may seem too high to try collaborating in the current environment. The sentiment is "we cannot afford to get this wrong and thus must play it safe." While failure is not desirable, this myth is a case of "the perfect being the enemy of the good." This logic discounts the simple fact that some element of failure is practically inevitable, with or without a partnership. The opportunities for things to go awry are abundant and unavoidable the first time an initiative is undertaken. Far from being a reason to avoid collaboration, that inevitability is a reason to embrace it. Mishaps will create opportunities for collective learning and improvement that would not have surfaced had the work been done in silos. A hallmark of a learning organization is its ability to recognize and embrace opportunities for improvement.

That said, failure is more common and consequential when taking on too much; it can be minimized by starting small and choosing achievable goals. Understanding how each organization works and where one another's strengths lie is the foundation for a solid, early success. In the long run, small wins will not be enough no matter how great the progress. But before moving to a more ambitious scale, the partnership should evolve and build a foundation of trust.

Power and Influence

Not surprisingly, in some communities, public health organizations and hospitals operate in parallel paths, or even as competitors, rather than as collaborators. While that model may have served some strategic purposes in the past, it is obsolete. Many of these organizations are now more willing to partner with one another and with other community organizations in order to create lasting impact. For example, Barnes Jewish Hospital and two other large health systems in St. Louis, Missouri, as well as the local health department, community organizations, other local hospitals and healthcare providers, partnered to complete community health needs assessments and implementation plans. They recognized that due to the competitive nature of their local health system, it was important to include other stakeholders, and have a community organization be the neutral convener of much of the work being done around population health.

A health department can also be an effective neutral convener, serving as the "face" of a collaborative initiative. Doing so sends a strong message: when these groups combine efforts and resources to address a health issue, they are more productive than when they work separately. Hospitals and health systems recognize that they can meaningfully influence the direction of this work while allowing the partnership to give the effort credibility, lasting reach, and impact. Some health departments fear that as hospitals grow more involved in population health initiatives, the traditional terrain of public health will be eroded, or at least called into question. The more that bureaucratic steps and bottle necks emerge, the more fearful some public health departments may become. The antidote to this is not for public health and hospitals to stay away from each other or to operate duplicate initiatives. Rather, the solution lies in getting to know one another even better, and leveraging the experience and insights of the right people from each organization.